

### **Other Health/Dental Insurance Information 2015**

Are you, or any member of your family (that is covered under your health plan with Tall Tree), covered by another health plan? ☐ **Yes** ☐ **No**

If you answered **No**, skip to signature.

If you answered **Yes**, please complete the following information:

Name of Other Health Plan

Group or Policy #

Telephone number of health plan

Date coverage began

(Please consult the other plan's ID card in order to give specific information we can use to coordinate your benefits with other health coverage you may have).

Name of all individuals covered under this health plan and any additional explanations or information about this coverage

Employee Signature

Date

Please Print Your Name

Please return signed form to Human Resources no later than: